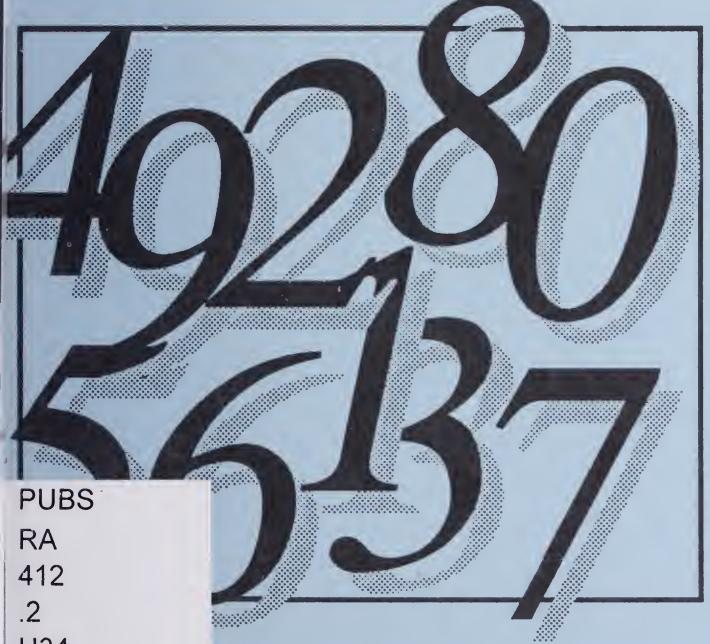
1993 HCFA Statistics



U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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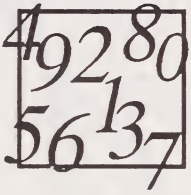
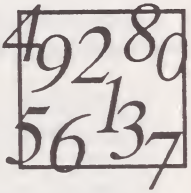
Preface



This reference booklet provides significant summary information about health expenditures and Health Care Financing Administration (HCFA) programs. The information presented was the most current available at the time of publication. Significant time lags may occur between the end of a data year and aggregation of data for that year.

The data are organized as follows:

Highlights



Growth in HCFA programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.5 million in 1967 to a projected 36.3 million in 1993, an 86 percent increase.

- Medicaid recipients (data on eligibles are not available) increased from about 10 million in calendar year 1967 to a projected 32.6 million in fiscal year 1993, an increase of 226 percent. Dependent children rose from 9.8 million in 1985 to 15.2 million in 1993, an increase of 55 percent.

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,707 in 1975 to 6,433 in 1993. Between 1975 and 1980, the number of hospitals classified as short-stay gradually increased from 6,084 to 6,111. However, by January 1993, the number decreased to 5,386. Total inpatient hospital beds have dropped from 51.5 beds per 1,000 enrolled in 1975 to 34.6 in 1993, a decrease of 49 percent.

- The total number of Medicare certified beds in short-stay hospitals showed a steady increase from less than 800,000 at the beginning of the program and peaked at 1,025,000 in 1984-86. Since that time, the number has dropped to slightly more than 959,000.

- The number of psychiatric hospitals grew to about 400 by 1976, where it remained until the start of the prospective payment system (PPS) in 1983. Since that time, the number has grown to 711.

- At the end of calendar year 1992, PPS covered 5,338 or 83 percent of all short-stay hospitals.

- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, and has been increasing ever since, reaching 10,854 by the beginning of 1993, an increase of 7.9 percent since 1992.

- After peaking in December 1970, the number of home health agencies (HHAs) remained stable during most of the decade. The number of HHAs accelerated with the passage of the Omnibus Budget Reconciliation Act of 1980, which permitted the certification of proprietary HHAs in States not having licensure laws. By December 1986, there were almost 6,000 participating facilities. Between 1992 and 1993, the number of HHAs has grown from 5,963 to 6,419, an increase of 7.6 percent.

- Since the Clinical Laboratory Improvement Act of 1988, (provision effective late 1991) the number and percentage of providers covered increased dramatically. Between 1991 and 1992, these grew from 90,126 to 148, 053, or an increase of 64.3 percent.

Expenditures

- National health expenditures were $51 billion in 1967, 6.3 percent of the gross domestic product (GDP) . By 1993, expenditures are projected to reach $903.3 billion, 14.4 percent of the GDP.

- Public expenditures on health amounted to $19 billion in 1967, 37 percent of total health expenditures. Public health expenditures are projected to reach $421 billion in 1993, 47 percent of total health expenditures.

- Federal health expenditures were 23 percent of all health expenditures in 1967 ($12 billion) and are projected to reach 32 percent in 1993 ($290 billion).

- National health expenditures per person were $247 in 1967 and are projected to reach $3,380 in 1993.

- National health expenditures are projected to reach $1,740 billion in the year 2000, representing 18.1 percent of the GDP.

- Medicare home health agency benefit payments have grown significantly from $4.8 billion in FY 1991 to $7.1 billion, an increase of nearly 48 percent.

- Medicare hospice expenditures have also grown rapidly, from $465 million in FY 1991 to $808 million in 1992, an increase of nearly 74 percent.

Utilization of Medicare and Medicaid services

- About 55 million persons are projected to receive services paid by Medicare or Medicaid in fiscal year 1993. Medicaid recipients as a percent of the total civilian population have risen from 10.2 percent in 1990 to 12.2 percent in 1992.

- One out of five, or more than 11 million persons, will use inpatient hospital services covered by Medicare or Medicaid during 1993. The ratio of Medicare aged users has grown from 367 per 1,000 enrolled in 1967 to 800 per 1,000 enrolled in 1991.

- Over four out of five, or about 46 million persons, are projected to receive reimbursable physician services under Medicare or Medicaid during 1993.

- About 29 million persons are projected to receive reimbursable outpatient hospital services under Medicare or Medicaid during 1993.

- Over 700,000 persons are projected to receive care in SNFs covered by Medicare during 1993. This represents a 16.7 percent increase since last year.

- Over 1.6 million persons are projected to receive care in nursing facilities, which include SNFs and all other intermediate care facilities other than mentally retarded, covered by Medicaid during 1993.

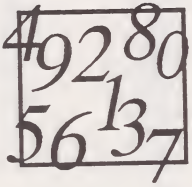
- Over 3.0 million persons are projected to receive reimbursable HHA visits under Medicare or Medicaid during 1993.

- Nearly 22 million persons are projected to receive prescribed drugs under Medicaid during 1993. This represents an increase of 10 percent since 1992.

I

Populations

Information about persons covered by Medicare or Medicaid



For Medicare, statistics are based on persons enrolled for coverage. For Medicaid, recipient counts are used as a surrogate of persons eligible for coverage, as well as for persons utilizing services. Statistics are available by major program categories, by demographic and geographic variables, and as proportions of the U.S. population. Utilization data organized by persons served may be found in the Utilization section.

Table 1
Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
July		In millions	
1966	19.1	19.1	—
1970	20.5	20.5	—
1975	25.0	22.8	2.2
1980	28.5	25.5	3.0
1985	31.1	28.2	2.9
1986	31.7	28.8	3.0
1987	32.4	29.4	3.0
1988	33.0	29.9	3.1
1989	33.6	30.4	3.2
1990	34.2	30.9	3.3
1991	34.9	31.5	3.4
1992	35.5	32.0	3.5
1993[1]	36.3	32.4	3.9
1994[1]	37.0	32.8	4.2

[1]Estimated data as of July 1993 and 1994, respectively.

NOTE: Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System and the Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 2
Medicare enrollment/coverage

	HI and/or SMI	HI	SMI	HI and SMI	HI only	SMI only
			In millions			
All persons	35.9	35.5	34.2	33.8	1.7	0.4
Aged persons	32.2	31.8	30.9	30.4	1.3	0.4
Disabled persons	3.7	3.7	3.3	3.3	0.4	([1])

[1]Number less than 50,000.

NOTES: Data as of March 1993. HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Enrollment Statistics.

Table 3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	35,900	15,237	20,663
Aged	32,206	12,969	19,237
65-74 years	18,062	7,983	10,079
75-84 years	10,535	3,993	6,542
85 years and over	3,608	993	2,615
Disabled	3,694	2,268	1,426
Under 45 years	1,320	837	483
45-54 years	925	568	357
55-64 years	1,449	863	586
White	30,347	12,844	17,503
Other races	4,332	1,876	2,456
Unknown	1,221	517	704

NOTES: Data as of March 1993. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Enrollment Statistics.

Table 4
Medicare enrollment/end stage renal disease trends

	HI and/or SMI	HI	SMI
July			
1980	66,741	66,254	64,896
1981	72,807	72,344	70,786
1982	76,117	75,707	73,705
1984	97,780	97,080	94,620
1986	120,060	118,946	116,093
1988	141,300	139,958	135,687
1990	172,078	170,629	163,708
1991	191,773	190,261	182,415
1992	207,356	205,918	196,994

NOTES: HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 5
Medicare enrollment/end stage renal disease demographics

	Number of enrollees
All persons	207,356
Age	
Under 25 years	7,744
25-44 years	48,967
45-64 years	72,967
65 years and over	77,678
Sex	
Male	112,064
Female	95,292
Race	
White	120,668
Other	79,887
Unknown	6,801

NOTE: Data as of July 1992.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 6
Medicare/health maintenance organizations (HMOs)

	Number of Plans	Enrollees in thousands
Total prepaid	176	2,406
HCPPs/GPPPs[1]	57	641
Total HMOs	119	1,765
TEFRA risk	93	1,603
Cost basis	22	140
Demonstrations	4	22

[1]Health care prepayment plans/group practice prepayment plans.

NOTES: Data as of March 1993. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Prepaid Health Care Operations and Oversight.

Table 7
Medicare enrollment/HCFA region

	Resident[1] population	Medicare[2] enrollees	Enrollees as percent of population
	In thousands		
All regions	[3]255,081	[3]34,822	13.7
Boston	13,200	1,953	14.8
New York	25,908	3,682	14.2
Philadelphia	26,384	3,828	14.5
Atlanta	46,214	6,897	14.9
Chicago	47,233	6,582	13.9
Dallas	29,135	3,537	12.1
Kansas City	12,134	1,884	15.5
Denver	7,920	946	11.9
San Francisco	37,186	4,256	11.4
Seattle	9,767	1,257	12.9

[1]The population estimates shown here are based on the July 1, 1992 resident population.
[2]Medicare enrollment data are as of July 1, 1992.
[3]Excludes persons in Puerto Rico, Guam, Virgin Islands, outlying areas, those with unknown State of residence, and those living in foreign countries.

NOTE: Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.
U.S. Bureau of the Census, Population Division, Population Estimates Branch.

Table 8
Aged population/projected

	1995	2000	2025	2050	2075
			In millions		
65 years and over	34.0	35.2	60.6	73.7	83.3
75 years and over	15.0	16.7	25.0	38.9	45.7
85 years and over	3.8	4.4	6.3	14.6	16.9

SOURCE: Social Security Administration, Office of Programs: Data from the Office of the Actuary.

Table 9
Life expectancy at age 65/trends

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1985	14.4	18.6
1986	14.5	18.7
1987	14.6	18.7
1988	14.6	18.7
1989	14.8	18.9
1990	14.9	18.9
1991	15.0	19.1
1992	15.0	19.0
1993[1]	15.0	19.0

[1]Estimated.

SOURCE: Social Security Administration, Office of Programs: Data from the Office of the Actuary.

Table 10
Elderly persons living below poverty level/trends

	Persons in millions	Percent
Year		
1966	5.1	28.5
1970	4.8	24.6
1980	3.9	15.7
1983	3.6	13.8
1984	3.3	12.4
1985	3.5	12.6
1986	3.5	12.4
1987	3.6	12.5
1988	3.5	12.0
1989	3.4	11.4
1990	3.7	12.2
1991	3.8	12.4

NOTES: Beginning in 1983, income estimates used for determining poverty level were based on improved measurement of interest income. Income estimates beginning 1987 are based on revised methodology.

SOURCE: U.S. Bureau of the Census: Poverty in the United States: 1991. Population estimates from Press Release CB92-276.

Table 11
Medicaid recipients/trends

	Fiscal year					
	1975	1980	1985	1992[1]	1993[1]	1994[1]
	In millions					
Total[2]	22.0	21.6	21.8	31.2	32.6	34.0
Age 65 years and over	3.6	3.4	3.1	3.7	3.8	3.9
Blind/disabled	2.5	2.9	3.0	4.5	4.9	5.4
Dependent children under 21 years of age	9.6	9.3	9.8	15.2	15.2	15.7
Adults in families with dependent children	4.5	4.9	5.5	7.0	7.8	8.0
Other Title XIX	1.8	1.5	1.2	0.6	0.9	0.9

[1]Estimated.

[2]Eligibility categories may not add to totals as some recipients are classified in more than one category during the year and due to the exclusion of unknowns.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics and the Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 12
Medicaid recipients/State buy-ins for Medicare[1]

	1975	1980	1985	1992
	In thousands			
All buy-ins	2,846	2,954	2,670	3,807
Aged	2,483	2,449	2,164	2,820
Disabled	363	504	505	987
	Percent of SMI enrollees			
All buy-ins	12.0	10.9	9.0	11.4
Aged	11.4	10.0	8.0	9.3
Disabled	18.7	18.9	19.2	31.8

[1]Recipients for whom the State paid Medicare supplementary medical insurance (SMI) premiums for month of July. Number of SMI enrollees includes those with unknown state of residence, but excludes those living in foreign countries.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Entitlement Requirements.

Table 13
Medicaid recipients/demographics

	Fiscal year 1992 Medicaid recipients	Percent distribution
	In millions	
Total recipients	31.2	100.0
Age	31.2	100.0
Under 6 years	7.4	23.8
6-20 years	7.7	24.7
21-64 years	9.2	29.4
65 years and over	3.9	12.4
Unknown	3.0	9.7
Sex	31.2	100.0
Male	10.3	33.1
Female	17.8	57.1
Unknown	3.0	9.8
Race	31.2	100.0
White	13.4	43.1
Other	13.3	42.7
Unknown	4.4	14.2

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Program Statistics, Division of Medicaid Statistics.

Table 14
Medicaid recipients/HCFA region

	Resident[1] population	Medicaid[2] recipients	Recipients as percent of population
	In thousands		
All regions	[3]255,081	31,150	12.2
Boston	13,200	1,527	11.6
New York	25,908	4,153	16.0
Philadelphia	26,384	2,768	10.5
Atlanta	46,214	5,940	12.9
Chicago	47,233	5,238	11.1
Dallas	29,135	3,620	12.4
Kansas City	12,134	1,211	10.0
Denver	7,920	620	7.8
San Francisco	[4]33,354	5,065	15.2
Seattle	9,767	1,008	10.3

[1]The population estimates shown are based on the July 1, 1992 population.
[2]Medicaid recipient data are as of fiscal year 1992.
[3]Excludes persons in outlying areas, those with unknown State of residence and those living in foreign countries.
[4] Excludes Arizona which operates a medical assistance program under a Section 1115 demonstration project.

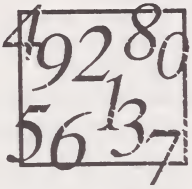
NOTE: Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Program Statistics, Division of Medicaid Statistics. U.S. Bureau of the Census, Population Division, Population Estimates Branch.

II

Providers/Suppliers

Information about institutions, agencies, or professionals who provide health care services and individuals or organizations who furnish health care equipment or supplies



These data are distributed by major provider/supplier categories, by geographic region, and by type of program participation. Utilization data organized by type of provider/supplier may be found in the Utilization section.

Table 15
Inpatient hospitals/trends

	1975	1980	1992	1993
Total hospitals	6,707	6,780	6,471	6,433
Beds in thousands	1,132	1,152	1,102	1,094
Beds per 1,000 enrollees	51.5	46.9	35.5	34.6
Short-stay	6,084	6,111	5,450	5,386
Beds in thousands	884	988	965	959
Beds per 1,000 enrollees	40.2	40.2	31.1	30.4
Psychiatric	358	408	712	711
Beds in thousands	207	136	99	96
Beds per 1,000 enrollees	9.4	5.5	3.2	3.0
Other long-stay	265	261	309	336
Beds in thousands	42	29	38	38
Beds per 1,000 enrollees	1.9	1.2	1.2	1.2

NOTES: Facility data as of January 1. Facility data exclude Christian science. Rates based on number of aged hospital insurance enrollees. Rates for 1993 based on July 1, 1992 enrollment excluding foreign countries.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System. Office of Research and Demonstration: Data from the Division of Program Studies.

Table 16
Medicare assigned claims/HCFA region

	Net assignment rates		
	1980	1991	1992
All regions	51.5	83.1	86.2
Boston	67.4	93.2	94.8
New York	51.8	84.6	87.6
Philadelphia	61.6	88.0	90.3
Atlanta	52.3	84.8	88.3
Chicago	47.6	80.6	84.0
Dallas	50.3	79.8	83.1
Kansas City	40.4	74.8	78.8
Denver	39.5	69.2	73.1
San Francisco	53.2	85.1	87.7
Seattle	31.3	64.7	69.7

NOTE: Calendar year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Information Management.

Table 17
Hospitals and units/status under the prospective payment system (PPS)[1]

Total hospitals	6,466
Hospitals under PPS	5,338
Hospitals receiving special consideration:	1,440
Regional referral centers	214
Sole community hospitals	664
Medicare dependent small rural hospitals	562
Non-PPS hospitals	1,128
Categorically exempt:	1,056
Psychiatric	717
All other non short-stay	339
Short-stay hospitals in waiver States or demonstrations	59
Short-stay hospitals in outlying areas	4
Cancer hospitals	9
Total excluded units	2,049
Psychiatric	1,279
Rehabilitation	770

[1] PPS is a reimbursement system whereby Medicare payment for inpatient operating costs is made at a predetermined specific rate for each discharge rather than on a reasonable-cost basis. All discharges are classified according to a list of diagnosis-related groups.

NOTE: Data as of March 1993.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System; Bureau of Policy Development: Division of Hospital Payment Policy; and the Health Standards and Quality Bureau: Data from the Division of Systems Management and Data Analysis.

Table 18
Long-term facilities/HCFA region

	Title XVIII and XVIII/XIX SNFs[1]	Title XIX-only SNFs	Nursing Facilities[2]	IMRs[3]
All regions	10,003	851	5,396	6,578
Boston	773	14	373	364
New York	842	18	86	1,093
Philadelphia	1,008	91	300	458
Atlanta	1,880	104	420	552
Chicago	2,241	167	1,320	2,050
Dallas	603	204	1,462	1,172
Kansas City	516	71	1,041	153
Denver	438	33	159	112
San Francisco	1,247	135	164	532
Seattle	455	14	71	92

[1]Skilled nursing facilities.
[2]Nursing facilities include: SNFs and all categories of ICF, other than " IMR".
[3]Institutions for mentally retarded.

NOTE: Data as of January 1993.

SOURCE: Health Care Financing Administration, Health Standards and Quality Bureau, Office of Survey and Certification. Data from the Division of System Management and Data Analysis.

Table 19
Other Medicare providers and suppliers/trends

	1975	1980	1992	1993
Home health agencies	2,254	2,858	5,963	6,419
Independent laboratories	2,994	3,448	[1]90,126	148,043
End stage renal disease facilities	—	975	2,211	2,321
Outpatient physical therapy	115	386	1,350	1,481
Portable X-ray	131	210	468	481
Rural health clinics	—	359	790	947
Comprehensive outpatient rehabilitation facilities	—	—	201	217
Ambulatory surgical centers	—	—	1,407	1,522
Hospices	—	—	1,108	1,208

[1]Includes providers newly covered under the Clinical Laboratory Improvement (CLIA) Amendment of 1988, provision effective 1992 .

NOTE: Data as of January.

SOURCE: Health Care Financing Administration, Health Standards and Quality Bureau, Office of Survey and Certification. Data from the Division of System Management and Data Analysis.

Table 20
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	5,386	10,854	6,419
		Percent of total	
Nonprofit	57.6	27.2	38.0
Proprietary	13.5	66.7	41.7
Government	28.9	6.1	20.3

NOTES: Data as of January 1993. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCES: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies. Health Standards Quality Bureau, Office of Survey and Certification: Data from the Division of System Management and Data Analysis.

Table 21
Periodic interim payment (PIP) facilities/trends

	1980	1985	1991	1992
Hospitals				
Number of PIP	2,276	3,290	1, 293	1,294
Percent of total participating	33.8	49.0	20.0	20.0
Skilled nursing facilities				
Number of PIP	203	228	975	978
Percent of total participating	3.9	3.4	9.1	9.0
Home health agencies				
Number of PIP	481	952	1,369	1,378
Percent of total participating	16.0	16.0	21.8	21.4

NOTES: Data from 1980 is as of September; all others are as of December. The Omnibus Budget Reconciliation Act of 1986 eliminated PIP for many inpatient hospitals.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Information Management.

Table 22
Physicians active in patient care/trends

	1980		1985		1992	
	Number	Percent	Number	Percent	Number	Percent
Physicians	[1]361,915	100.0	[1]431,527	100.0	[2]650,570	100.0
Specialties						
Medical	105,049	29.0	132,519	30.7	62,869	9.7
Surgical	103,312	28.5	118,955	27.6	158,485	24.4
Other	96,871	26.8	117,109	27.1	246,118	37.8
Primary Care	56,683	15.7	62,944	14.6	[3]183,098	28.1

[1]Non-federal physicians only.
[2]Includes physicians, doctors of osteopathy (DOs), and limited licensed practitioners (LLPs).
[3]Specialties include general practice, family practice and internal medicine.

SOURCES: For 1980 and 1985: American Medical Association: *Physician Characteristics and Distribution in the U.S.* Chicago: 1992. 1992 data are dervived from the HCFA Unique Physician Indentification Number (UPIN) Directory.

Table 23
Physicians/HCFA region

	Physicians active in patient care	Physicians per 100,000 population
All regions	[1]650,570	[2]251
Boston	45,601	345
New York	85,102	288
Philadelphia	73,079	277
Atlanta	102,674	222
Chicago	118,023	250
Dallas	59,757	205
Kansas City	29,148	240
Denver	17,065	215
San Francisco	97,307	261
Seattle	22,814	234

[1]Excludes physicians in foreign countries.
[2]Includes 1990 civilian population for Puerto Rico, Guam and the Virgin Islands, but excludes the civilian population for foreign countries.

NOTES: Physicians as of January 1993. Civilian population as of July 1, 1992.

SOURCE: HCFA Unique Physician Identification Number (UPIN) Directory.

Table 24
Inpatient hospitals/HCFA region

	Short-stay hospitals	Beds per 1,000 enrollees	Long-stay facilities	Beds per 1,000 enrollees
All regions	5,386	30.4	1,047	4.3
Boston	225	25.2	79	6.9
New York	388	30.6	71	7.4
Philadelphia	442	26.8	116	5.1
Atlanta	1,023	31.2	192	3.3
Chicago	950	33.0	147	3.1
Dallas	803	36.3	189	5.0
Kansas City	473	34.3	54	3.2
Denver	295	31.9	47	5.5
San Francisco	566	28.1	130	3.0
Seattle	221	22.3	22	2.5

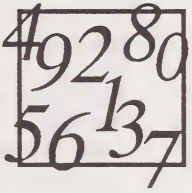
NOTES: Data as of January 1993. Rates based on number of aged hospital insurance enrollees as of July 1, 1992.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

III

Expenditures

Information about spending for health care services by Medicare, Medicaid, and in the Nation as a whole



Health care spending at the aggregate levels is distributed by source of funds, types of service, geographic area, and broad beneficiary or eligibility categories. Direct out-of-pocket, other private, and non-HCFA-related expenditures are also covered in this section. Expenditures on a per-unit-of-service level are covered in the Utilization section.

Table 25
HCFA and total Federal disbursements

	Fiscal year 1992 in billions
Gross national product (current dollars)	$5,869.0
Total Federal budget[1]	1,380.9
Percent of gross national product	(23.5)
Department of Health and Human Services[1]	538.8
Percent of Federal budget	(39.0)
HCFA budget	
Medicare benefit payments	129.2
Medicaid medical assistance payments	65.4
HCFA program management	2.1
State and local administration/training	2.5
Other administrative expenses	0.8
Peer review organizations	0.2
Total (unadjusted)	200.1
Offsetting and proprietary receipts	-13.2
Total net of offsetting and proprietary receipts[1]	186.9
Percent of Federal budget	(13.5)

[1]Includes off-budget entities, net of offsetting receipts.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Table 26
Program outlays/trends

	Total	Medicare	Medicaid[1]
		In billions	
Fiscal year[2]			
1980	$60.8	$35.0	$25.8
1990	179.3	107.2	72.1
1992	247.4	129.2	118.2
1993[3]	285.0	144.7	140.3

[1]Medicaid amounts include both Federal and State share of benefit payments and administrative costs.
[2]The reporting period has been changed from calendar to fiscal year.
[3]Estimated.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Table 27
Benefit outlays by program

	1967	1991	1992	1993[1]
Annually		In billions		
HCFA program outlays	$5.1	$202	$243	$279
Medicare	3.2	114	129	145
HI	2.5	68	81	90
SMI	0.7	45	49	55
Medicaid	1.9	88	114	[2]135
Federal share	NA	50	65	77
Monthly		In billions		
HCFA program outlays	$.423	$16.8	$20.3	$23.3
Medicare	.264	9.5	10.8	12.1
HI	.209	5.7	6.7	7.5
SMI	.055	3.8	4.0	4.6
Medicaid	.158	7.3	9.5	11.2
Federal share	NA	4.2	5.5	6.5
Hourly		In millions		
HCFA program outlays	$.579	$23.0	$27.7	$31.9
Medicare	.362	13.0	14.7	16.5
HI	.286	7.8	9.2	10.3
SMI	.076	5.2	5.5	6.2
Medicaid	.217	10.0	13.0	15.4
Federal share	NA	5.7	7.5	8.8
Minutely		In thousands		
HCFA program outlays	$10	$384	$463	$532
Medicare	6	217	246	275
HI	5	130	154	172
SMI	1	86	92	104
Medicaid	4	167	217	256
Federal share	NA	95	124	147

[1]Estimated.
[2]Does not include administrative costs incurred by the States.

NOTES: Fiscal year data. HI is hospital insurance. SMI is supplementary medical insurance. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Table 28
Program benefit payments/HCFA region

	Medicare[1]	Medicaid	
		Computable[2]	Net adjusted[3]
		In millions	
All regions	$129,179	$115,874	$66,235
Boston	7,463	9,232	4,635
New York	15,014	23,567	11,588
Philadelphia	15,164	11,432	6,483
Atlanta	25,492	17,182	11,338
Chicago	22,451	18,914	10,806
Dallas	12,566	11,893	8,232
Kansas City	5,708	4,578	2,855
Denver	2,702	2,276	1,488
San Francisco	18,736	13,528	6,889
Seattle	3,884	3,273	1,921

[1]Distribution by region is estimated. Excludes residence unknown and residents of foreign countries.
[2]Total medical assistance payments computable for Federal funding.
[3]Net adjusted Federal share. Does not include administrative expenditures.

NOTES: Data as of fiscal year 1992. Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System; Office of Budget and Administration: Data from the Division of Budget; and the Medicaid Bureau: Data from the Division of Financial Management.

Table 29
National health care/projections

	Calendar year		
	1993	1995	2000
National total in billions	$903.3	$1,101.9	$1,739.8
Percent of GDP	14.4	15.6	18.1
Per capita amount	$3,380	$4,050	$6,148
Source of funds		Percent of total	
Private	53.4	52.0	49.4
Public	46.6	48.0	50.6
Federal	32.1	33.2	35.5
State/local	14.5	14.8	15.1

NOTES: GDP is gross domestic product.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics. HCFA Review, Fall 1992, "National Health Expenditures Projections Through 2030."

Table 30
Medicare/trust fund projections

	Fiscal year		
	1992	1993[1]	1994[1]
		In billions	
HI benefit payments[2]	$80.6	$90.0	$101.4
Aged	71.6	79.9	89.9
Disabled	9.0	10.1	11.5
SMI benefit payments	48.6	54.6	62.6
Aged	42.8	48.4	55.5
Disabled	5.8	6.2	7.2

[1]Estimated.
[2]Excludes peer review organization (PRO) expenditures.

NOTES: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Table 31
Medicare/type of benefit

	Fiscal year 1992 benefit payments in millions[1]	Percent distribution
Total HI[2]	$80,584	100.0
Inpatient hospital	69,007	85.6
Skilled nursing facility	3,692	4.6
Home health agency	7,077	8.8
Hospice	808	1.0
Total SMI	48,595	100.0
Physician/other suppliers	32,304	66.5
Outpatient hospital	10,671	22.0
Home health agency	75	0.2
Group practice prepayment	3,810	7.8
Independent laboratory	1,735	3.6

[1]Includes the effect of regulatory items and recent legislation but not proposed law.
[2]Excludes peer review organization (PRO) expenditures.

NOTES: HI is hospital insurance. SMI is supplementary medical insurance. Numbers may not add to totals because of rounding. Benefits by type of service are estimated and subject to change.

SOURCE: Health Care Financing Administration, Office of the Budget and Administration: Data from the Division of Budget.

Table 32
Medicaid/type of service

	Fiscal year	
	1991	1992
	In billions	
Total vendor payments	$77.0	$91.5
	Percent of total	
Inpatient services	28.4	28.3
General hospitals	25.8	25.9
Mental hospitals	2.6	2.4
Nursing facility services[1]	26.9	25.7
Intermediate care facility (MR) services[2]	10.0	9.3
Physician services	6.4	6.7
Dental services	0.9	0.9
Other practitioner services	0.6	0.6
Outpatient hospital services	5.6	5.8
Clinic services	2.9	3.1
Laboratory and radiological services	1.2	1.1
Home health services	5.3	5.3
Prescribed drugs	7.0	7.4
Family planning services	0.5	0.6
Early and periodic screening	0.4	0.6
Rural health clinic services	0.1	0.1
Other care	3.9	4.4

[1]Nursing facilities include: SNFs and all other categories for ICF, other than "MR".
[2]"MR" indicates mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Program Statistics, Division of Medicaid Statistics.

Table 33
Medicaid/payments by eligibility status

	Fiscal year 1992 vendor payments	Percent distribution
	In millions	
Total	$91,480	100.0
Age 65 years and over	29,089	31.8
Blind/disabled	34,004	37.2
Dependent children under 21 years of age	14,758	16.1
Adults in families with dependent children	12,403	13.6
Other Title XIX	1,053	1.2

NOTE: Numbers may not add to totals due to the exclusion of unknowns and because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 34
National health care/trends

	Calendar year			
	1965	1980	1992[1]	1993[1]
National total in billions	$41.6	$250.1	$819.9	$903.3
Percent of GDP[2]	5.9	9.2	13.9	14.4
Per capita amount	$204	$1,064	$3,098	$3,380
Source of funds		Percent of total		
Private	75.3	58.0	54.1	53.4
Public	24.7	42.0	45.9	46.6
Federal	11.6	28.8	31.6	32.1
State/local	13.2	13.3	14.3	14.5

[1]Estimates from the HCFA Review, Fall 1992, National Health Expenditures Projections Through 2030.
[2]GDP is gross domestic product.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 35
National health care/type of expenditure[1]

	National total in billions	Per capita amount	Private as a percent of total	Public
Total	$903.3	$3,380	53.4	46.6
Health services and supplies	875.9	3,278	53.9	46.1
Personal health care	803.7	3,008	54.0	46.0
Hospital care	358.8	1,343	41.4	58.6
Physicians' services	167.3	626	61.3	38.7
Nursing home care	74.3	278	42.6	57.4
Other personal care	203.4	761	74.3	25.7
Other services and supplies	72.2	270	52.8	47.2
Research and construction	27.4	102	37.1	62.9

[1]Projected for calendar year 1993.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 36
Personal health care/payment source

	Calendar year			
	1970	1980	1992[1]	1993[1]
	In billions			
Total	$64.9	$219.4	$727.1	$803.7
	Percent			
Total	100.0	100.0	100.0	100.0
Private	65.5	60.3	54.7	54.0
Out-of-pocket	39.5	27.1	21.4	21.1
Other private	26.0	33.2	33.3	32.9
Public	34.6	39.7	45.3	46.0
Federal	22.6	28.9	32.7	33.2
State and Local	12.0	10.8	12.6	12.8

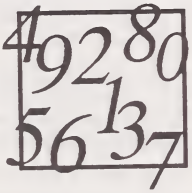
[1]Estimates from the HCFA Review, Fall 1992, "National Health Expenditures Projections Through 2030".

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

IV

Utilization

Information about the use of health care services



Utilization information is organized by persons receiving services and alternately by services rendered. Measures of health care usage include: persons served, units of service (e.g., discharges, days of care, etc.), and dimensions of the services rendered (e.g., average length of stay, charge per person or per unit of service). These utilization measures are aggregated by program coverage categories, provider characteristics, type of service, and demographic and geographic variables.

Table 37
Medicare/short-stay hospital utilization

	1990	1991	1992
Discharges[1]			
Total in millions[2]	10.5	10.7	11.0
Rate per 1,000 enrollees	313	314	315
Days of care			
Total in millions	94	94	93
Rate per 1,000 enrollees	2,805	2,747	2,669
Average length of stay per discharge	9.0	8.7	8.5
Total charges per day	$1,060	$1218	$1,386

[1]Includes admissions and transfers to excluded units within PPS hospitals.
[2]The population base excludes HI enrollees residing in foreign countries.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 38
Medicare long-term care/trends

	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
Calendar year				
1982	252	9	1,172	40
1983	264	9	1,338	45
1984	299	10	1,522	50
1985	315	10	1,576	51
1986	304	10	1,601	50
1987	293	9	1,575	49
1988	384	12	1,613	49
1989	[1]636	[1]19	1,721	51
1990	638	19	1,978	58
1991	671	19	2,223	63

[1]Increased utilization coincident with changes enacted under the Medicare Catastrophic Coverage Act of 1988.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 39
Medicare average length of stay/trends

	Fiscal year					
	1984	1988	1989	1990	1991	1992
All short-stay hospitals	9.1	8.9	8.9	9.0	8.7	8.5
PPS hospitals[1]	8.0	[2]8.6	[2]8.5	8.6	8.4	8.1
Excluded units	18.0	19.7	19.7	19.5	18.7	18.0

[1]Bills for stays that overlap a hospital's transition into the Prospective Payment System (PPS) are aggregated and included in PPS. Average length of stay may differ from that based on that portion of stays actually covered by PPS.
[2]Includes pre-PPS experience, hospitals in waiver States, cancer hospitals, PPS excluded units, demonstration hospitals, and hospitals in outlying areas.

NOTES: Fiscal year data. Average length of stay is shown in days. For all Short-stay and PPS hospitals, data are based on a 20-percent sample of Medicare HI enrollees (20-percent MEDPAR file for 1984 and 1985). Data for 1990 through 1992 are based on 100-percent MEDPAR. Data may differ from other sources or from the same source with a different updated cycle.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 40
Medicare persons served/trends

	Calendar year				
	1967	1975	1980	1985	1991
Aged persons served per 1,000 enrollees					
HI and/or SMI	367	528	638	722	800
HI	203	221	240	219	212
SMI	365	536	652	739	830
Disabled persons served per 1,000 enrollees					
HI and/or SMI	—	450	594	669	728
HI	—	219	246	228	209
SMI	—	471	634	715	799

NOTES: Includes beneficiaries in foreign countries. HI is hospital insurance. SMI is supplementary medical insurance. Persons served are those for whom Medicare Trust Fund payments were made. Based on July 1, enrollment. Rates may differ from estimates using risk-based enrollment.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 41
Medicare persons served/projections

	Fiscal year				
	1992	1993	1994	1995	1996
	In millions				
HI					
Aged					
Enrollees	30.9	31.3	31.8	32.1	32.5
Persons served	6.7	6.9	7.0	7.1	7.3
Disabled					
Enrollees	3.6	3.7	3.9	4.1	4.3
Persons served	0.7	0.8	0.8	0.9	0.9
SMI					
Aged					
Enrollees	30.5	30.9	31.3	31.6	32.0
Persons served	25.4	25.9	26.4	26.9	27.3
Disabled					
Enrollees	3.1	3.2	3.3	3.4	3.4
Persons served	2.4	2.6	2.8	3.1	3.3

NOTES: HI is hospital insurance. SMI is supplementary medical insurance. Enrollment represents actuarial estimates of average monthly enrollment during the fiscal year.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 42
Medicare persons served/HCFA region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions[1]	25,178	800	2,465	732
Boston	1,459	831	123	753
New York	2,943	803	285	682
Philadelphia	2,878	844	261	749
Atlanta	4,972	830	566	761
Chicago	4,820	824	458	734
Dallas	2,556	824	258	727
Kansas City	1,408	827	117	745
Denver	661	791	57	682
San Francisco	2,643	699	266	717
Seattle	839	701	74	698

[1]Excludes residents of foreign countries.

NOTES: Data as of calendar year 1991 for persons served under Hospital Insurance and/or Supplementary Medical Insurance. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 43
Medicare/end stage renal disease (ESRD)

	Calendar year	
	1991	1992[1]
Total enrollees[2]	191,773	207,356
Dialysis patients[3]	142,208	157,069
Outpatient	117,088	128,988
Home	25,120	28,081
Transplants performed[4]	9,961	10,115
Living donor	2,277	2,391
Cadaveric donor	7,599	7,579
Living Unrelated	85	145
Average dialysis payment rate		
Hospital-based facilities	$130	$130
Freestanding facilities	$126	$126

[1]Preliminary.
[2]Medicare ESRD enrollees as of July 1.
[3]Includes Medicare and non-Medicare patients receiving dialysis as of December 31.
[4]Includes kidney transplants for Medicare and non-Medicare patients.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System and the Bureau of Policy Development: Data from the Division of Special Payment Programs.

Table 44
Medicaid/type of service

	Fiscal year 1992 Medicaid recipients
	In thousands
Total	31,150
Inpatient services	
General hospitals	5,790
Mental hospitals	77
Nursing facility services	1,573
Intermediate care facility (MR) services	151
Physician services	21,683
Dental services	5,717
Other practitioner services	4,725
Outpatient hospital services	15,167
Clinic services	4,128
Laboratory and radiological services	11,850
Home health services	926
Prescribed drugs	22,070
Family planning services	2,559
Early and periodic screening	4,982
Rural health clinic services	747
Other care	6,941

NOTES: Nursing facilities include: SNFs and all categories of ICF, other than "MR". "MR" indicates mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Program Statistics, Division of Medicaid Statistics.

Table 45
Medicaid/units of service

	Fiscal year 1992 units of service
	In thousands
General hospital	
Total discharges	5,248
Recipients discharged	3,733
Total days of care	28,777
Nursing facility	
Total days of care	384,814
Intermediate care facility/mentally retarded	
Total days of care	50,916
Physician visits	134,371
Rural health clinic visits	2,480
Home health service visits	109,293
Drug prescriptions	295,697

NOTES: Based on 49 reporting States and the District of Columbia (Data are not reported for Arizona and Puerto Rico). Nursing facilities include: SNFs and all categories of ICF, other than mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Program Statistics, Division of Medicaid Statistics.

V

Administrative/Operating

Information on activities and services related to oversight of the day-to-day operations of HCFA programs

Included are data on Medicare contractors, contractor activities and performance, HCFA and State agency administrative costs, quality control, and summaries of the operation of the Medicare trust funds.

Table 46
Medicare administrative expenses/trends

	Administrative expenses	
	Amount in millions	As a percent of benefit payments
HI Trust Fund		
1970	$149	3.1
1975	259	2.5
1980	497	2.1
1985	813	1.7
1990	774	1.2
1991	934	1.4
1992	1,191	1.5
SMI Trust Fund		
1970	217	11.0
1975	405	10.8
1980	593	5.8
1985	922	4.2
1990	1,524	3.7
1991	1,505	3.3
1992	1,661	3.4

NOTES: Fiscal year data. HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 47
Medicare/contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	42	25
Other	5	8

NOTES: Data as of January 1993. Reference to intermediaries as Part A has been dropped in recognition of the fact that intermediaries also service Part B institutional bills as well as Part A claims.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Acquisitions and Contracts.

Table 48
Medicare/appeals

	Intermediary reconsiderations	Carrier reviews
Number processed	36,546	6,467,415
Percent reversal rate[1]	47.4	63.2

[1]Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 1992.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Table 49
Medicare/claims processing bottom line unit costs

	Unit cost per claim[1]			
	1975	1980	1991[2]	1992
Intermediaries	$3.84	$2.96	$3.01	$2.80
Carriers	2.90	2.33	1.86	1.71

[1]Effective 1992, HCFA started including all functions in determining the "bottom line" unit costs for funding intermediaries and carriers.
[2]1991 data have been recalculated to reflect the "bottom line" unit costs.

NOTE: Fiscal year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Contractor Financial Management.

Table 50
Medicare/claims processing

	Intermediaries	Carriers
Claims processed in millions	101.1	550.3
Total costs in millions	$444.5	$1,064.1
Claims processing costs in millions	$168.9	$613.1
Claims processing unit costs	$1.60	$1.05
Range		
High	$2.03	$1.38
Low	$1.20	$0.91

NOTE: Data for fiscal year 1992.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Contractor Financial Management.

Table 51
Medicare/claims received

	Claims received
Intermediary claims received in thousands	103,299
	Percent of total
Inpatient hospital	12.1
Outpatient hospital	47.9
Home health agency	10.7
Skilled nursing facility	1.9
Other	27.5
Carrier claims received in thousands	554,619
	Percent of total
Assigned	86.2
Unassigned	13.8

NOTE: Data as of calendar year 1992.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Information Management.

Table 52
Medicare/charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	412.9	66.4
Percent reduced	86.2	82.9
Total covered charges		
Amount in millions	$67,667	$6,215
Percent reduced	39.7	18.5
Amount reduced per claim	$65.10	$17.32

NOTES: Data as of calendar year 1992. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge, medical necessity and global fee/rebundling reductions.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Information Management.

Table 53
Medicaid/administration

	Fiscal year	
	1991	1992[1]
	In thousands	
Total payments computable for Federal funding	$3,810,695	$4,283,189
Federal share of current expenditures:		
Family planning	9,636	12,042
Design, development or installation of MMIS[2]	34,775	22,700
Skilled professional medical personnel	128,760	123,064
Operation of an approved MMIS[2]	418,056	441,236
Other financial participation	1,516,844	1,739,662
Mechanized systems not approved under MMIS[2]	28,668	42,209
Total administration	2,136,739	2,380,913
Net adjusted Federal share[3]	2,154,848	2,364,867

[1]Data as of April, 1993. State reported expenditures. Net adjusted Federal share includes Health Care Financing Administration (HCFA) adjustments. Excludes expenditures for survey and certification and fraud control unit activities.

[2]Medicaid Management Information System.

[3]Includes Federal share of current expenditures plus State reported and HCFA adjustments.

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Financial Management.

Table 54
Quality control/Medicare Part B carriers

	Average carrier error rate				
	1977	1985	1990[1]	1991[1]	1992[2]
Occurrence [3]	8.7	6.4	6.1	4.6	4.2
Assigned	8.3	5.7	—	—	—
Unassigned	9.2	7.7	—	—	—
High	—	—	8.7	6.8	—
Medium	—	—	8.0	5.8	—
Low	—	—	5.5	4.5	—
EMC	—	—	—	—	3.0
Paper	—	—	—	—	5.2
Payment/deductible [4]	1.9	1.8	1.2	1.0	0.8
Assigned	1.8	1.7	—	—	—
Unassigned	2.0	1.8	—	—	—
High	—	—	1.1	1.1	—
Medium	—	—	1.4	0.9	—
Low	—	—	1.2	1.0	—
EMC	—	—	—	—	0.6
Paper	—	—	—	—	1.0

[1] As of July 1, 1989, under the revised Part B Quality Assurance System, the assigned and unassigned divisions were eliminated. The sample was divided into three groups using the amount of submitted charges (high, medium, and low). High-medium-low were calculated only between 1990 and 1991.
[2] As of January 1, 1992, HCFA began calculating error rates for electronic (EMC) and hard copy (paper) claims.
[3] Claims processing errors per 100 line items.
[4] Dollar error per $100 of submitted charges without nonreview penalty.

NOTE: Calendar year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Performance Evaluation.

Table 55
Quality control/Medicaid

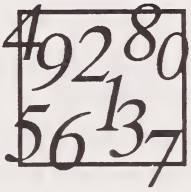
	Eligibility national average error rate[1] in percent of dollars
Fiscal year	
1985	2.7
1986	2.5
1987	2.3
1988	2.2
1989	2.0
1990	2.0
1991	1.9
1992[2]	1.9

[1]Excludes Supplemental Security Income determinations.
[2]Preliminary.

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Program Performance.

Reference

Selected reference material including cost-sharing features of the Medicare program, program financing, and Medicaid Federal medical assistance percentages



Program financing

Medicare/source of income

Hospital Insurance trust fund:

1. Payroll taxes*
2. Transfers from railroad retirement account
3. General revenue for
   a. uninsured persons
   b. military wage credits
4. Premiums from voluntary enrollees
5. Interest on investments

*Contribution rate	1992	1993	1994
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Calendar year 1993 maximum taxable base: $135,000

Supplementary Medical Insurance trust fund:

1. Premiums paid by or on behalf of enrollees
2. General revenue
3. Interest on investments

Medicaid/financing

1. Federal contributions (ranging from 50 to 80 percent for fiscal year 1994)
2. State contributions (ranging from 20 to 50 percent for fiscal year 1994)

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Medicare deductible and coinsurance amounts

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/93)	$676/benefit period
Regular coinsurance days (1/1/93)	$169/day for 61st thru 90th day
Lifetime reserve days (1/1/93)	$338/day (60 nonrenewable days)
SNF coinsurance days (1/1/93)	$84.50/day for 21st thru 100th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/93)	$221/month
Limitations:	
Inpatient psychiatric hospital days	190 nonrenewable days
Part B (effective date)	**Amount**
Deductible (1/1/91)	$100 in reasonable charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance	20 percent of allowed charges
Premium (1/1/93)	$36.60/month
Limitations:	
Outpatient treatment for mental illness	No limitations
Licensed physical therapist's services in home or office (1/1/91)	$600 (80% of maximum annual program payment of $750)

SOURCE: Health Care Financing Administration, Office of Legislation and Policy: Data from the Divisions of Medicare Part A and Medicare Part B Analysis.

Geographical jurisdictions of HCFA regional offices and Federal medical assistance percentages (FMAP) fiscal year 1993

I. Boston	FMAP
Connecticut	50
Maine	62
Massachusetts	50
New Hampshire	50
Rhode Island	54
Vermont	60

II. New York	FMAP
New Jersey	50
New York	50
Puerto Rico	50
Virgin Islands	50
Canada	—

III. Philadelphia	
Delaware	50
District of Columbia	50
Maryland	50
Pennsylvania	55
Virginia	50
West Virginia	76

IV. Atlanta	
Alabama	71
Florida	55
Georgia	62
Kentucky	72
Mississippi	79
North Carolina	66
South Carolina	71
Tennessee	68

V. Chicago	
Illinois	50
Indiana	63
Michigan	56
Minnesota	55
Ohio	60
Wisconsin	60

VI. Dallas	
Arkansas	74
Louisiana	74
New Mexico	74
Oklahoma	70
Texas	64

VII. Kansas City	
Iowa	63
Kansas	58
Missouri	60
Nebraska	61

VIII. Denver	
Colorado	54
Montana	71
North Dakota	72
South Dakota	70
Utah	75
Wyoming	67

IX. San Francisco	
Arizona	66
California	50
Hawaii	50
Nevada	52
American Samoa	50
Guam	50
N. Mariana Islands	50
Mexico	—

X. Seattle	
Alaska	50
Idaho	71
Oregon	62
Washington	55

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Financial Management.

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